EXHIBIT 12

Deposition Of:
Vincent Reyes, MD

Volume II

November 7, 2022

Tammy L. Thomsen
vs.
NaphCare, Inc.; et al.

Case No.: 3:19-CV-00969-AC

SYNERGY
LEGAL
LITIGATION SUPPORT SERVICES

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF OREGON - PORTLAND DIVISION

TAMMY L. THOMSEN, Personal Representative of the Estate of DALE L. THOMSEN, Deceased,
Plaintiff,
v. No. 3:19-CV-00969-AC
NAPHCARE, INC., an Alabama Corporation; WASHINGTON COUNTY, a government body in the State of Oregon; PAT GARRETT, in his capacity as Sheriff for Washington County; ROBERT DAVIS, an Individual; DON BOHN, an Individual; ERIN LARSEN, an Individual; LISA WAGNER, an Individual; JULIE RADOSTITZ, MD, an Individual; MELANIE MENEAR, an Individual; KATHY DEMENT, an Individual; RACHEL ECLEVIA, an Individual; KATIE BLACK, an Individual; ANDREA JILLETTE, also known as ANDREA GILLETTE, an Individual; MORGAN HINTHORNE, an Individual; RACHEL STICKNEY, an Individual; and JOHN/JANE DOES 1-10,
Defendants.

VIDEOTAPED DEPOSITION OF VINCENT REYES, MD
Taken in behalf of the Defendants
Volume II
Monday, November 7, 2022

BE IT REMEMBERED THAT, pursuant to the Federal Rules of Civil Procedure, the videotaped deposition of VINCENT REYES, MD, was taken before Kimberly M. Harrison, an Oregon Certified Shorthand Reporter, Washington Certified Court Reporter, and Registered Professional Reporter, on Monday, the 7th of November, 2022, at 10:05 a.m., in the law offices of Paulson Coletti, 1022 NW Marshall Street, Suite 450, Portland, Oregon.

PROCEEDINGS

THE VIDEOGRAPHER: Here begins the video recorded deposition of Dr. Vincent Reyes in the matter of Thomsen versus NaphCare, et al.

Will counsel please state your appearances for the record.

MR. COLETTI: John Coletti for the plaintiff.

MS. HOULIHAN: Meg Houlihan for NaphCare and the individual NaphCare defendants.

MS. MANDT: Heidi Mandt for Washington County.

THE VIDEOGRAPHER: The stenographer will now swear in the witness.

VINCENT REYES, MD,
called as a witness, having first been duly sworn, testified under oath as follows:

EXAMINATION

BY MS. HOULIHAN:

Q Hi, Dr. Reyes.

A Hello.

Q My name is Meg Houlihan. We met for the first time briefly off the record just now.

of the questions that was asked of me last time was that -- where in the record does Tammy Thomsen describe any interaction with the jail system. And I knew that it had been done a few times, but I didn't know in the records where it was. So I looked in the exhibit, and I found the details.

Q About how long did you spend preparing for your deposition today?

A About 28 hours.

Q And that's just for your continued deposition?

A Yes.

Q And I don't want to know the substance of these conversations, but did you speak at all with Mr. Jones or Mr. Coletti in preparation for today?

A I did.

Q About how long were those conversations?

A Just an hour. And that was last Tuesday.

Q Was that an hour of with each of the attorneys together?

A No. Just with Mr. Coletti.

Q You have some documents in front of you. Could you tell me what you have there?

A You have -- you were given some of them. I think that pretty much is it, in different forms.

MS. HOULIHAN: Okay. Let's go ahead and

mark this as Exhibit 5.

(Exhibit No. 5 marked.)

BY MS. HOULIHAN: (continuing)

Q I'm marking, as Exhibit 5, the file that your attorney prepared and handed me right before this deposition. I'll hand it to you. And if you could just confirm that it contains all the documents you have in front of you.

A Yeah.

Q So you don't have anything else in front of you that is not contained in Exhibit 5?

A There's a summary of the exhibits. I made a -- like, a spreadsheet of the exhibits. That's all.

Q That's --

A But it's a spreadsheet of the exhibits.

Q When you say "exhibits," is that deposition exhibits?

MR. COLETTI: I think he's referencing Exhibit A, that we outline all of the documents that were provided.

MS. HOULIHAN: Okay. Great.

THE WITNESS: Yeah. Noth -- nothing new.

MS. HOULIHAN: Let's mark this as Exhibit 6.

(Exhibit No. 6 marked.)

Q How often do you treat patients going through alcohol withdrawal?

A So as the primary provider for them, never, recently. However, as a consultant who goes -- who is asked to go in and evaluate patients who are going through withdrawal and evaluate their cardiac conditions, my guess would be five or ten a year.

Q When you --

A And I've been in practice for 37 years.

Q So you think you see about five to ten people going through withdrawal, and that's held true for 30 years?

A Well, it was actually more when I was in training. And early on, when I was an assistant professor at Wayne State University, and they had the Detroit Receiving Hospital, which is an inner city -- an inner city hospital, I think I saw more of it then. But since I've been here in Oregon, I see less of it. So probably -- maybe five or ten a year since I've been here in Oregon, since 1990. But prior to that, in my training, I saw at least twice that.

Q Let's focus on the time period that you've been in Oregon, since 1990. Have you ever diagnosed someone with alcohol withdrawal since 1990?

A As the primary provider, no. Usually the

examined that person face-to-face?

A I can't answer it "yes" or "no." I can answer it by saying, I do not make diagnoses on patients without seeing them. Otherwise, it's a chart diagnosis that someone else has made.

Q Okay. I'm not quite sure if I've gotten an answer to the question.

A So the question -- and to make a diagnosis, you have to go through some medical record history and this thing called a physical exam. So I don't make diagnoses without doing a physical exam. And that could just be eyesight. I don't need -- in the world of COVID, sometimes you don't go and examine the patient, but you -- you observe them, and you get the history from a chart, and you see what they're doing.

And there are a number of other things that go into diagnosing a person. But I would not make that diagnosis -- frankly, most diagnoses without examining the patient, even if it's visual.

Q Okay. Thank you.

Have you ever conducted any research on the effects of alcohol withdrawal on a person's heart?

A No.

Q Have you ever done research, in general, on alcohol withdrawal?

A No.
Q Is it fair --
A So can I ask a question? Is -- does "research" mean do I look into the literature, or do I perform the research?
Q Perform the research.
A No.
Q Is it fair to say that alcohol withdrawal is not your area of expertise?
A That's correct.
Q You're not an addiction specialist?
A No.
Q I would like to take a look at your initial expert report. I believe you have that in front of you in Exhibit 5.
A I have this. It's the same thing. May -- May 16th?
Q Yes.
A Yes.
Q And for the record, this was Exhibit 3 to your original deposition.
A Okay.
Q You state in paragraph --
MR. COLETTI: I'm sorry. Was that the May report or the March?

A He was irritable. He was irritable.

Q Let me finish my question.

A Okay.

Q What symptoms of alcohol withdrawal did Mr. Thomsen exhibit before 3:30 in the morning on June 28, 2017?

A Well, he was -- he was irritable, and he said -- I think he started to have some of these -- I think the initial discussion or mention of something in his ear was the day before.

Q Other than mentioning that he had tissue in his ear the day before his death, did he exhibit any other symptoms of alcohol withdrawal?

A I -- I don't think it was real obvious. The obvious change was the morning of 6/28. The other -- the other discussions or mentions are kind of subtle. So, again, alcohol withdrawal can manifest itself in many ways. I'm not an expert. I'm not going to claim to be an expert. But it wasn't as obvious as the change in his clinical picture at 3:30 in the morning on 6/28.

Q Okay. I want to be clear. When you say there were more subtle symptoms, are you referring to anything else other than Mr. Thomsen's report of tissue in his ear?

A He was very irritable.

attributed to alcohol withdrawal?

A Do I know that?

Q Yes.

A I do not know that.

Q Is it possible that his seizures were caused by something other than alcohol withdrawal?

A Yes.

Q You're not a neurologist, right?

A No.

Q You're not here to opine on the cause of Mr. Thomsen's past seizures, right?

A No.

Q I'm looking back at your original report, Exhibit 4. You still have that in front of you?

A I do.

Q In paragraph 10, you say, "The stress of alcohol withdrawal (the timing of withdrawal symptoms is consistent with how long he had been off alcohol) did create a significant (and documented) rise in blood pressure and heart rate."

I want to focus in on what you have in parentheses there, "The timing of withdrawal symptoms is consistent with how long he had been off alcohol." Do you know when Mr. Thomsen had his last drink?

A I do not.

Q Mr. Thomsen was arrested on June 25, 2017, around 4:30 p.m.; is that right?

A Correct.

Q So at the very most -- sorry. Let me start over. So you would agree with me that Mr. Thomsen must have had his last drink sometime before 4:30 p.m. on June 25th, right?

A We can assume that.

Q You don't know whether that was an hour before his arrest, right?

A I do not know that.

Q You don't know if it was 24 hours before his arrest?

A I do not know that for sure. However, from his family's account, he drank every day. So it could have been earlier in the day, during the day, up until the time of his arrest.

Q Do you know what time of day Mr. Thomsen usually drank?

A I do not.

Q Is it possible that he typically drank in the evenings?

A It's possible.

Q And if he drank in the evenings and arrest -- was arrested at 4:30 p.m., he might not have had a drink

on June 25th yet, right?

A It's possible.

Q So it's possible that he had not had a drink for at least 24 hours before his arrest, right?

A Correct.

Q So when you say in your report that, "The timing of withdrawal symptoms is consistent with how long he had been off alcohol," you don't actually know how long Mr. Thomsen had been off alcohol, right?

A I did not ask him the question. I went by the history that his family gave, that if he drank every day, it was at the very earliest the 24th, the very latest on the 25th. And --

Q But back to my question. You don't know exactly how long he had been off alcohol, right?

A Correct.

Q Are you aware that Mr. Thomsen's arresting officer checked "no" for whether Mr. Thomsen had consumed alcohol in the last 24 to 48 hours?

A He checked -- I think he denied everything. What -- what they put on the form is, it was not a positive, "Yes, he drank alcohol." So it was a "no."

Q I'm talking about the arresting officer.

A Yeah.

Q There was a question about whether Mr. Thomsen

Go ahead.

THE WITNESS: In general, yes.

BY MS. HOULIHAN: (continuing)

Q Would you rely on this article for general information about alcohol withdrawal?

A Yes.

Q If you could look at page 3 of Exhibit 8, please, under the section "Delirium Tremens."

A Uh-huh.

Q Do you see that?

A Yes.

Q This article states, "Virtually all patients who develop delirium tremens experience some symptoms of minor alcohol withdrawal prior to the onset of delirium tremens." Do you agree with that statement?

A I do. Again, I'm not an expert, but I would agree with it.

Q If you could look at page 11 of Exhibit 8, please, under "Summary and Recommendations." Do you see that?

A Uh-huh.

Q It states, "Dangerous diagnoses can mimic or coexist with alcohol withdrawal. Alcohol withdrawal remains a clinical diagnosis." Do you agree with that statement?

Q So that's a "yes" to my question?

A In certain patient populations, that's correct.

Q Mr. Thomsen had 100 percent occlusion of his left coronary artery, right?

A Correct.

Q He had 70 percent stenosis of his right coronary artery, right?

A Yes.

Q This is a severe condition, right?

A Yes. But he seemed to -- he was asymptomatic up until that day.

Q So until June 28th, Mr. Thomsen had no symptoms of his severe coronary artery disease, right?

A No.

Q Did he have symptoms?

A Not -- not that I could see.

Q His level of occlusion of his coronary arteries could be fatal, right?

A No.

Q It cannot be fatal?

A Well, if -- he existed with that combination of coronary disease. It's not -- not clear how long he had that combination of coronary disease. The LAD and the circumflex, according to the coroner -- or the --

yeah, the coroner were -- were chronic. And he had a 70 percent proximal RCA stenosis. We've seen this many, many times. I've seen it many, many times, where patients can exist and do fine.

Q Back to my question.

A And it's not fatal on its own, as long as you have collaterals. And if the collaterals from the right to the left are patent, patients do fine. If, however, the conditions change abruptly -- this is -- this is where we see patients all the time with mild heart attacks, and they have other contributing acute conditions. It could be stress. It could be a big workout. It could be anemia. It could be an infection. It could be severe dehydration causing hypotension. It could be a pneumonia.

All of these things cause -- cause an acute stress, and they compromise or change the supply-demand ratio of oxygen going to the heart. So something needs to happen that's a significant change to cause a sudden cardiac death in these patients.

Q But with someone who has 100 percent occlusion --

A Uh-huh.

Q -- of their left anterior artery --

A Uh-huh.

A Okay.

Q -- in your deposition. I would like to turn your attention to the second page of Exhibit 11, and I'm looking at the paragraph that begins, "Mr. Thomsen's coronary disease was medically treatable." Do you see that.

A I do.

Q Okay. You state that, "Had the RCA abruptly and spontaneously closed, it is likely he would have had a fatal arrhythmic event." What does "RCA" mean here?

A The right coronary artery.

Q Are you saying that it's possible Mr. Thomsen's right coronary artery could have abruptly and spontaneously closed?

A At any time?

Q Well, what are you saying here in this paragraph?

A What I'm saying is that the rest of his heart, including the areas that were provided -- previously provided circulation, was being provided by the right coronary artery. Circulation was provided to his heart via the right coronary artery. And that was his only source of myocardial profusion, because the other two arteries were closed. So if that artery closed, he would have died -- probably had a sudden cardiac death,

if there was an acute thrombosis of that artery.

Q You state here also, "The postmortem did demonstrate a moderate to severe narrowing, but not occluded RCA stenosis, hence still providing collaterals to the remainder of the compromised heart." Are you characterizing Mr. Thomsen's heart as compromised?

A At the time of this event, yes.

Q And "this event," you mean his death?

A At the time of his death, I believe his circulation to his heart was -- there was a mismatch between the demand and the supply. The supply was fixed. The demand was substantial and different than when he was at rest when he came into the facility.

So it doesn't mean that the -- the right coronary artery had changed in character or there was a thrombosis to the right coronary artery. But the ischemia was significant during this event. Why? Because the demand increased.

Q Would you characterize anyone who has 100 percent occlusion of their left coronary artery as having a compromised heart?

A Not as long as there's not -- as long as there are adequate collaterals from the other artery, which in this case there were, it wasn't necessarily compromised.

Q But 100 percent occlusion would still be a

condition that could be concerning, right?

A I would -- if it was my heart, I would want it fixed.

Q So you say here -- I'm turning to the third page of your rebuttal report. You say, "Severe multivessel coronary disease is treatable, and in Mr. Thomsen's case, coronary artery bypass is the standard of care." Do you think Mr. Thomsen needed coronary artery bypass surgery?

A I think he needed to have revascularization of all three arteries of his heart -- the LAD, the circumflex, and the RCA. Bypass surgery, 15 years ago, would have been the stand -- the standard of care in him. Nowadays, there are multivessel PCI stenting, which has very similar outcomes as bypass surgery.

So this is a classic patient, who after a diagnostic angiogram, which he would if -- you know, had he presented at the hospital and been stabilized, a diagnostic coronary angiogram would have been totally indicated, low risk in his case. And then he would have gone to -- again, as someone who still practices cardiology full-time, he would have been referred to a surgical center -- OHSU, Legacy, St. V's. And his case would have been presented -- would have been presented to a multidisciplinary committee of doctors, including

surgeons and interventional cardiologists.

Q Doctor, I'm trying to understand the statement in your report. You say, "Coronary artery bypass is the standard of care." Are you saying that Mr. Thomsen needed a coronary artery bypass?

A I -- I think he -- that would have been his best option.

Q And that's because of the level of occlusion of his coronary arteries, right?

A Correct. He had a left main equivalent, which is the LAD and the circumflex, occluded. So I think that would have been the best option for him.

Q Coronary artery bypass, that's a surgery, right?

A Yes.

Q That's a serious surgery, right?

A It's a heart surgery.

Q You wouldn't recommend coronary artery bypass surgery unless you thought someone really needed it, right?

A I think if -- if the decision is made to proceed with the coronary artery bypass surgery, it's a very deliberate decision based on a lot of different factors. So if they needed it, we'd recommend it.

Q And someone would need that because they have

an otherwise life-threatening condition?

A I'm sorry. Ask the question.

Q Would someone need coronary artery bypass surgery because they have an otherwise life-threatening condition?

A What do you mean "otherwise"?

Q That if they don't receive the bypass surgery, they have a condition that could be fatal?

A It's a serious condition. I mean, he obviously -- this fellow existed with this anatomy for who knows how long, and he did fine. However, with this degree of stress -- for example, if someone is walking around with this anatomy and they had any symptoms at all and I say, "Well, let's do a treadmill on you," and they got on the treadmill and they flunked it miserably and we did an angiogram and found their anatomy, I would say, "You need a bypass surgery or you could die," yes.

Q And you're saying that about Mr. Thomsen, right? You're saying coronary artery bypass surgery was the standard of care for him, right?

A I think it is the best option for him. Had he -- he had come into the hospital, been stabilized, had an angiogram, I think he would have -- that would have been the best option for him.

Q Can coronary artery bypass surgery itself be

A Which is May 16th.
Q -- eight pages. Yes.
A Okay.
Q Turn to the page that starts with "STS Adult Cardiac Surgery Database."
A Oh, okay. I see. Oh, the short-term risk calculator?
Q The calculated risk scores. Do you see that?
A Yeah. It's at the bottom of the page.
Q Are you looking at --
A The risk calculator incorporates -- blah, blah, blah.

THE COURT REPORTER: Sorry. Doctor, I can't hear you.

THE WITNESS: Oh, sorry.

BY MS. HOULIHAN: (continuing)

Q Let me hold up the page that I'm looking at. Are you looking at the one that says "Calculated Risk Scores"?
A Oh, here it is. Got it.
Q Do you see "Risk of Mortality" there?
A I do.
Q And it lists risk of mortality as .834 percent?
A Correct.

Q Did you assume all of the lab values that allowed you to calculate that risk?

A I think I actually stated -- yeah, I did. I assumed a couple of them.

Q Okay.

A Like, the renal function was something I assumed. But then I went back and revised it. And that's why I'm saying it went from 0.8 to 0.5. Because his renal function was actually better than the renal function that I assumed.

Q Did you assume a platelet count?

A Yeah.

Q Did you assume the last creatinine level?

A Creatinine, yeah.

Q And I'm apologizing for my pronunciations here.

Did you assume a hematocrit level?

A Yes, I did.

Q Okay. You don't actually know what these levels were, right?

A No. But when I did know them, I plugged them into the revision. And it went from the 0.8 to 0.5.

Q Did you ever find out Mr. Thomsen's platelet count?

A I think it was in one of the labs. I think it

was in -- I think it was in one of the labs.

Q In his autopsy report?

A No. They don't do that.

Q Okay. What labs are you referring to?

A The hospital labs.

Q From the time of his death?

A No.

Q From when?

A They don't -- I think it was OHSU.

Q Was that in 2011?

A Uh-huh.

Q So six years before Mr. Thomsen's death?

A Right.

Q Okay. And you're assuming that his lab levels remained constant for six years?

A There was no indication anywhere in any record subsequent to that that there was any anemia, thrombocytopenia, neutropenia, infection, or anything that had changed.

Q Back to my question.

A No.

Q You're assuming that they -- that those levels remained constant for six years?

A I -- I did.

Q Okay. You also list morbidity or mortality as

report.

Q You didn't --

A But I don't -- I don't remember that, honestly.

Q You didn't see a history of marijuana use in his medical records?

A I don't remember that offhand.

Q Is 100 percent occlusion of the left anterior artery sometimes called "the widow-maker"?

A It is.

Q Is it the most common cause of acute death in the United States?

MR. COLETTI: Object to the form.

Go ahead and answer the question.

THE WITNESS: Are you asking if coronary artery disease or the LAD itself?

BY MS. HOULIHAN: (continuing)

Q The LAD itself.

A It used to be.

Q When you say, "It used to be," what time frame are you referring to?

A Well, before -- before we started doing complex interventions, like STEMIs, it used to be.

Q So --

A But now patients come in -- and I started the

STEMI program at Tuality, and I was very much involved in the STEMI program, in 1994, at St. V's. But when we started doing STEMIs, which stands for ST-elevation myocardial infarction, we would treat the LAD stenosis. So since then and since the STEMI protocols have been activated and are so effective, that doesn't happen much anymore. Why? Because we treat them.

Q Do you know what the most common cause of acute death in the United States currently is?

A Probably coronary disease.

Q Not -- not necess --

A It's the -- it's the cause of death in a lot of countries.

Q And that's not necessarily occlusion of the LAD, but occlusion of the coronary arteries in general?

A Yes. And in this -- if I can qualify, that -- that has to do more with acute occlusions, acute thrombotic occlusions. That's not what Mr. Thomsen had. He did not have an acute thrombotic occlusion of the LAD. He had an occlusion of the LAD and the circumflex, which probably occurred over many years, and he didn't notice it. He didn't feel it. He wasn't aware of it. Because the right coronary artery is dominant, clearly defined on the autopsy report, and it provided circulation to the rest of the heart.

Q But it was narrowing, his right coronary artery, right?

A It was. Do I know if it was narrowing? I know it was narrowed.

Q I would like to turn your attention to page 3 of Exhibit 11, your rebuttal report. Again, this is the May 2022 report.

A Okay.

Q And I'm looking at the paragraph that begins, "Severe multivessel coronary disease."

A Yes.

Q And I'm looking towards the bottom of the paragraph, and you say, "The other obvious scenario is he" -- Mr. Thomsen -- "might not have even survived to get to the hospital." Are you saying here that it's possible that Mr. Thomsen would have died on his way to the hospital on June 28, 2017?

A It's possible.

Q You can't rule it out?

A No.

Q Looking at page 2 of Exhibit 11, you state in the paragraph that begins, "It has been well demonstrated" -- do you see that paragraph?

A Yes.

Q In the middle of the paragraph you say, "Had

CERTIFICATE

I, Kimberly M. Harrison, an Oregon Certified Shorthand Reporter, a Washington Certified Court Reporter, and a Registered Professional Reporter, hereby certify that VINCENT REYES, MD, personally appeared before me at the time and place set forth in the caption hereof; that at said time and place, I reported in stenotype all testimony adduced and other oral proceedings had in the foregoing matter; that thereafter my notes were reduced to typewriting under my direction; and the foregoing transcript, pages 1 to 89, both inclusive, constitutes a full, true, and correct record of such testimony adduced and oral proceedings had and of the whole thereof.

Witness my hand and CSR seal at Portland, Oregon, this 17th day of November, 2022.

Kimberly M. Harrison
Oregon CSR No. 12-0423
Expires 9/30/2023
Washington CCR No. 3287
Expires 7/13/2023